# Diablo Canyon 2
# 1Q/2008 Plant Inspection Findings

## Initiating Events

## Mitigating Systems

**Significance:** G Mar 31, 2008
Identified By: NRC
Item Type: NCV NonCited Violation
**Failure to Demonstrate that the Unit 2 Containment Atmosphere Particulate Radioactivity Monitor Performance was Being Effectively Controlled per 10 CFR 50.65(a)(2)**
The inspectors identified a noncited violation of 10 CFR 50.65(a)(2), after Pacific Gas and Electric Company failed to effectively control performance monitoring of the Unit 2 containment atmosphere particulate radiation monitor through appropriate preventive maintenance. Eight functional failures of the radiation monitor occurred between November 2006 and January 2008. The licensee did not categorize any of these failures as Maintenance Rule functional failures.

This finding is greater than minor because it is associated with the mitigating systems cornerstone attribute of equipment performance and it affects the cornerstone objective to ensure the availability, reliability, and capability of the systems that respond to initiating events to prevent undesirable consequences. The inspectors evaluated the significance of this finding using Inspection Manual Chapter 0609, “Significance Determination Process,” Phase 1, Appendix A. The inspectors determined that this finding was of very low safety significance because this is not a design or qualification deficiency, does not represent a loss of a system safety function or safety function of a single train, and does not screen as potentially risk significant due to external events. The inspectors also determined that this finding has a crosscutting aspect in the area of human performance associated with the work practices component because engineering staff failed to follow the November 2006 revision to the licensee maintenance rule procedure that would have required each failure to be counted as a maintenance rule functional failure. Engineering staff incorrectly concluded that the revision was not applicable to the radiation monitors and therefore did not implement the change.

Inspection Report# : 2008002 *(pdf)*

**Significance:** G Feb 17, 2008
Identified By: NRC
Item Type: NCV NonCited Violation
**Failure to Maintain the Integrity of an Auxiliary Building Fire Door**
On February 17, 2008, the inspectors identified a noncited violation of Technical Specification 5.4.1.d, “Fire Protection Program,” after Pacific Gas and Electric failed to maintain the integrity of an auxiliary building fire door. The inspectors identified that the latching mechanism on Fire Door 348 was degraded and not engaged. The unlatched fire door resulted in a reduction in fire confinement capability. The door was required to provide a 1½-hour fire barrier between two plant fire areas. The licensee had several prior opportunities to identify the degraded fire door. Security and operations personnel passed through the affected fire area several times each day.

This finding is greater than minor because the degraded fire barrier affected the mitigating systems cornerstone external factors attribute objective to prevent undesirable consequences due to fire. Using Manual Chapter 0609, Appendix F, “Fire Protection Significance Determination Process,” the inspectors determined this finding is within the fire confinement category and the fire barrier was moderately degraded because the door latch was not functional. The inspectors concluded that this finding is of very low safety significance because a non-degraded automatic full area water based fire suppression system was in place in the exposing fire area. This finding was entered into the corrective action program as Action Request A0719774. This finding has a crosscutting aspect in the area of problem identification and resolution associated with the corrective action program component because plant personnel did not

maintain a low threshold for identifying issues.

Inspection Report# : 2008002 *(pdf)*

**Significance:** G Jun 30, 2007
Identified By: NRC
Item Type: NCV NonCited Violation
**Failure to Scope Reactor Cavity and Containment Structure Sump Level Indication Systems Into the Maintenance Rule Program**
GREEN. The inspectors identified a Green, noncited violation of 10 CFR 50.65(b) was identified for the failure of engineering personnel to include the reactor cavity and containment structure sump level indication systems into the scope of its program for monitoring the effectiveness of maintenance. Specifically, between April 14, 2007 and May 17, 2007, Units 1 and 2 experienced multiple failures of the reactor cavity and containment structure sump level indications. These systems are required by the plant's Technical Specifications in order to promptly identify and take actions for reactor coolant system leaks before they can potentially develop into a loss of coolant accident. Additionally, the inspectors discovered that Emergency Operating Procedure ECA-3.1, "SGTR With Loss of Reactor Coolant - Subcooled Recovery Desired," Revision 18, utilized the containment structure sump level indication for mitigative actions. Based on the fact that the systems are used to mitigate a loss of coolant accident and were used in the emergency operating procedures, the inspectors determined that the systems should have been included in Pacific Gas and Electric Company's program for monitoring the effectiveness of maintenance. This issue was entered into Pacific Gas and Electric Company's corrective action program as Action Request A0696295.

The finding is greater than minor because it is associated with the Mitigating Systems Cornerstone attribute of equipment performance and affects the cornerstone objective to ensure the availability, reliability, and capability of systems that respond to initiating events to prevent undesirable consequences (i.e., core damage). Using Inspection Manual Chapter 0609, "Significance Determination Process," Phase 1 Worksheet, the finding is determined to have very low safety significance since it did not represent a loss of system safety function, an actual loss of safety function of a single train for greater than its Technical Specification allowed outage time, or screen as potentially risk-significant due to a seismic, flooding, or severe weather initiating event. This finding has a crosscutting aspect in the area of human performance, associated with the decision-making component, in that Pacific Gas and Electric Company failed to use conservative assumptions in evaluating the function and use of the sump level indications in mitigating the effects of design basis accidents (H.1(b)).
Inspection Report# : 2007003 *(pdf)*

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# Barrier Integrity

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# Emergency Preparedness

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# Occupational Radiation Safety

**Significance:** G Feb 13, 2008
Identified By: NRC
Item Type: NCV NonCited Violation
**Failure to Follow Procedures, per Technical Specification 5.4.1**
The inspectors identified a noncited violation of Technical Specification 5.4.1 for failure to follow a licensee procedure. Specifically, while touring the Unit 2 spent fuel pool on February 13, 2008, the inspectors observed workers performing fuel inspections on the fuel bridge. The inspectors noted that the physical location of a continuous air monitor, an AMS-4, was in the southeast corner of the floor. Ventilation flow in this area was north to south with negative ventilation centered on the spent fuel pool. Section 2.2 of Procedure RCP D-430 states, in part, the purpose

of the continuous air monitors was to alert personnel to changes in radiological conditions and that locations are selected based on their potential as contributors to airborne activity. The location of the continuous air monitor was not appropriate to alert the workers of changing radiological conditions. During review of this occurrence, the inspectors were made aware of a similar issue. Specifically, Action Request A0666110 was opened on May 3, 2006, to evaluate the adequacy of AMS 4 placement in the fuel building during fuel moves. This action request was currently open with a resolution date of December 15, 2008.

This finding is greater than minor because it is associated with the occupational radiation safety program and process attribute and affected the cornerstone objective, in that the failure to monitor for radioactive material in the air had the potential to increase personnel dose. This occurrence involves workers unplanned, unintended or potential for such dose; therefore, this finding was evaluated using the occupational radiation safety significance determination process. The inspectors determined that this finding was of very low safety significance because it did not involve: (1) an as low as is reasonably achievable planning or work control issue; (2) an overexposure; (3) a substantial potential for overexposure; or (4) an impaired ability to assess dose. This finding also has a crosscutting aspect in the area of problem identification and resolution, corrective action component, because the licensee failed to take timely corrective actions to address safety issues.

Inspection Report# : 2008002 *(pdf)*

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## Public Radiation Safety

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## Physical Protection

Although the NRC is actively overseeing the Security cornerstone, the Commission has decided that certain findings pertaining to security cornerstone will not be publicly available to ensure that potentially useful information is not provided to a possible adversary. Therefore, the cover letters to security inspection reports may be viewed.

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## Miscellaneous

Last modified : June 05, 2008